



PRIOR AUTHORIZATION POLICY

POLICY: Cystic Fibrosis – Kalydeco Prior Authorization Policy

- Kalydeco® (ivacaftor tablets and oral granules – Vertex)

REVIEW DATE: 02/08/2023; selected revision 05/10/2023

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THE FOLLOWING COVERAGE POLICY APPLIES TO HEALTH BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. CERTAIN CIGNA COMPANIES AND/OR LINES OF BUSINESS ONLY PROVIDE UTILIZATION REVIEW SERVICES TO CLIENTS AND DO NOT MAKE COVERAGE DETERMINATIONS. REFERENCES TO STANDARD BENEFIT PLAN LANGUAGE AND COVERAGE DETERMINATIONS DO NOT APPLY TO THOSE CLIENTS. COVERAGE POLICIES ARE INTENDED TO PROVIDE GUIDANCE IN INTERPRETING CERTAIN STANDARD BENEFIT PLANS ADMINISTERED BY CIGNA COMPANIES. PLEASE NOTE, THE TERMS OF A CUSTOMER'S PARTICULAR BENEFIT PLAN DOCUMENT [GROUP SERVICE AGREEMENT, EVIDENCE OF COVERAGE, CERTIFICATE OF COVERAGE, SUMMARY PLAN DESCRIPTION (SPD) OR SIMILAR PLAN DOCUMENT] MAY DIFFER SIGNIFICANTLY FROM THE STANDARD BENEFIT PLANS UPON WHICH THESE COVERAGE POLICIES ARE BASED. FOR EXAMPLE, A CUSTOMER'S BENEFIT PLAN DOCUMENT MAY CONTAIN A SPECIFIC EXCLUSION RELATED TO A TOPIC ADDRESSED IN A COVERAGE POLICY. IN THE EVENT OF A CONFLICT, A CUSTOMER'S BENEFIT PLAN DOCUMENT ALWAYS SUPERSEDES THE INFORMATION IN THE COVERAGE POLICIES. IN THE ABSENCE OF A CONTROLLING FEDERAL OR STATE COVERAGE MANDATE, BENEFITS ARE ULTIMATELY DETERMINED BY THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT. COVERAGE DETERMINATIONS IN EACH SPECIFIC INSTANCE REQUIRE CONSIDERATION OF 1) THE TERMS OF THE APPLICABLE BENEFIT PLAN DOCUMENT IN EFFECT ON THE DATE OF SERVICE; 2) ANY APPLICABLE LAWS/REGULATIONS; 3) ANY RELEVANT COLLATERAL SOURCE MATERIALS INCLUDING COVERAGE POLICIES AND; 4) THE SPECIFIC FACTS OF THE PARTICULAR SITUATION. COVERAGE POLICIES RELATE EXCLUSIVELY TO THE ADMINISTRATION OF HEALTH BENEFIT PLANS. COVERAGE POLICIES ARE NOT RECOMMENDATIONS FOR TREATMENT AND SHOULD NEVER BE USED AS TREATMENT GUIDELINES. IN CERTAIN MARKETS, DELEGATED VENDOR GUIDELINES MAY BE USED TO SUPPORT MEDICAL NECESSITY AND OTHER COVERAGE DETERMINATIONS.

CIGNA NATIONAL FORMULARY COVERAGE:

OVERVIEW

Kalydeco, a cystic fibrosis transmembrane conductance regulator (CFTR) potentiator, is indicated for the treatment of **cystic fibrosis (CF)** in patients ≥ 1 months of age who have one mutation in the CFTR gene that is responsive to Kalydeco potentiation based on clinical and/or *in vitro* assay data.¹

In patients with unknown genotype, a FDA-cleared CF mutation test should be used to detect the presence of the CFTR mutation followed by verification with bidirectional sequencing when recommended by the mutation test instructions for use.¹ Kalydeco is not effective in patients with CF who are homozygous for the F508del mutation in the CFTR. A patient must have at least one CFTR mutation responsive to Kalydeco to be indicated. Table 1 lists mutations that are responsive to Kalydeco based on 1) a positive clinical response and/or 2) *in vitro* data in Fischer rat thyroid cells indicating that Kalydeco increases chloride transport to $\geq 10\%$ over baseline (% of normal).

Table 1. List of CFTR Gene Mutations that Produce CFTR Protein and are Responsive to Kalydeco.¹

2789+5G—>A	F311del	I148T	R75Q	S549N
3272-26A—>G	F311L	I175V	R1070Q	S549R
3849+10kbC—>T	F508C	I807M	R1070W	S945L
711+3A—>G	F508C;S1251N	I1027T	R117C	S977F
A120T	F1052V	I1139V	R117H	S589N

A234D	F1074L	K1060T	R347H	S737F
A349V	G1069R	L206W	R352Q	S1159F
A1067T	G1244E	L320V	R117G	S1159P
A455E	G1349D	L967S	R117L	T338I
D110E	G178R	L997F	R117P	T1053I
D1152H	G551D	L1480P	R170H	V232D
D110H	G551S	M152V	R347L	V562I
D192G	G194R	M952I	R553Q	V754M
D1270N	G314E	M952T	R668C	V1293G
D924N	G576A	P67L	R792G	W1282R
D579G	G970D	Q237E	R933G	Y1014C
E193K	Y1032C	Q237H	R1162L	G178E
E882K	G1249R	Q359R	R1283M	
E56K	H939R	Q1291R	S1251N	
E831X	H1375P	R74W	S1255P	

CFTR – Cystic fibrosis transmembrane regulator.

Guidelines

Guidelines from the CF Foundation (2018) provide guidance on the use of CFTR therapy in patients with CF. Symdeko (tezacaftor/ivacaftor and ivacaftor tablets) and Trikafta (elexacaftor/tezacaftor/ivacaftor tablets; ivacaftor tablets, co-packaged and elexacaftor/tezacaftor/ivacaftor oral granules; ivacaftor oral granules) are not addressed and neither is the lower pediatric age indication for Kalydeco.² For adults ≥ 6 years of age with CF due to a gating mutation other than G551D or R117H (e.g., G178R, S549N, S549R, G551S, G1244E, S1251N, S1255P, or G1249D), the guidelines make a conditional recommendation for treatment with Kalydeco. For those with the R117H mutation, the guideline panel made a conditional recommendation for treatment with Kalydeco for adults ≥ 18 years of age and for children 6 to 17 years of age with a percent predicted forced expiratory volume in 1 second (ppFEV1) $< 90\%$. For individuals with R117H mutation, the guidelines recommend against treatment with Kalydeco for children 12 to 17 years of age with a (ppFEV1) $> 90\%$ and in children < 6 years of age.

POLICY STATEMENT

Prior Authorization is recommended for prescription benefit coverage of Kalydeco. All approvals are provided for the duration noted below. Because of the specialized skills required for evaluation and diagnosis of patients treated with Kalydeco as well as the monitoring required for adverse events and efficacy, approval requires Kalydeco to be prescribed by or in consultation with a physician who specializes in the condition being treated.

• **Kalydeco® (ivacaftor tablets and oral granules – Vertex)**
is(are) covered as medically necessary when the following criteria is(are) met for fda-approved indication(s) or other uses with supportive evidence (if applicable):

FDA-Approved Indication

1. Cystic Fibrosis. Approve for 1 year in patients who meet the following criteria (A, B, and C):

A) Patient is \geq 1 month of age; AND

B) Patient has at least ONE of the following mutations in the cystic fibrosis transmembrane conductance regulator gene: E56K, P67L, R74W, D110E, D110H, R117C, E193K, L206W, R347H, R352Q, A455E, D579G, S945L, S977F, F1052V, K1060T, A1067T, G1069R, R1070Q, R1070W, F1074L, D1152H, D1270N, G551D, G178R, S549N, S549R, G551S, G1244E, S1251N, S1255P, G1349D, 2789+5G—>A, 3272-26A—>G, 3849+10kbC—>T, 711+3A—>G, E831X, R117H, A120T, A234D, A349V, D192G, D924N, E882K, F311L, F311delF508C, F508C;S1251N, G178E, G194R, G314E, G576A, G970D, G1249R, H939R, H1375P, I148T, I175V, I807M, I1027T, I1139V, L320V, L967S, L997F, L1480P, M152V, M952I, M952T, Q237E, Q237H, Q359R, Q1291R, R75Q, R117G, R117L, R117P, R170H, R347L, R553Q, R668C, R792G, R933G, R1162L, R1283M, S589N, S737F, S1159F, S1159P, T338I, T1053I, V232D, V562I, V754M, V1293G, W1282R, Y1014C, or Y1032C; AND

C) The medication is prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.

CONDITIONS NOT COVERED

• **Kalydeco® (ivacaftor tablets and oral granules – Vertex)** is(are) considered experimental, investigational or unproven for ANY other use(s) including the following (this list may not be all inclusive; criteria will be updated as new published data are available):

1. Cystic Fibrosis (CF), Patients who are Homozygous for the phe508del (F508del) Mutation in the Cystic Fibrosis Transmembrane Regulator Gene. Efficacy results from a double-blind, placebo controlled trial in patients with CF who were homozygous for the phe508del mutation in the CFTR gene showed no statistically significant difference in forced expiratory volume in 1 second (FEV₁) over 16 weeks of Kalydeco treatment compared with placebo.¹ In a Phase II trial in patients homozygous for the F508del (n = 112), Kalydeco did not result in an improvement in FEV₁ relative to placebo.³

2. Cystic Fibrosis (CF), Patients with Unknown Cystic Fibrosis Transmembrane Regulator Gene Mutation. An FDA-cleared CF mutation test should be used to detect the presence of the cystic fibrosis transmembrane regulator mutation prior to use of Kalydeco.¹

3. Combination Therapy with Orkambi, Symdeko, or Trikafta. Orkambi, Symdeko, and Trikafta contain ivacaftor, the active agent in Kalydeco and therefore are not indicated in combination with Kalydeco.

REFERENCES

1. Kalydeco® tablets and oral granules [prescribing information]. Cambridge, MA: Vertex; May 2023.
2. Ren CL, Morgan RL, Oermann C, et al. Cystic Fibrosis Foundation Pulmonary Guidelines: Use of cystic fibrosis transmembrane conductance regulator modulator therapy in patients with cystic fibrosis. *Ann Am Thorac Soc*. 2018;15(3):271-280.
3. Flume PA, Liou TG, Borowitz DS, et al; VX08-770-104 Study Group. Ivacaftor in subjects with cystic fibrosis who are homozygous for the F508del-CFTR mutation. *Chest*. 2012;142(3):718-724.

HISTORY

Type of Revision	Summary of Changes	Review Date
Annual Revision	No criteria changes.	02/09/2022
Selected Revision	Cystic Fibrosis (CF): Approval duration was changed to 1 year; previously approval duration was 3 years.	06/22/2022
Annual Revision	No criteria changes.	02/08/2023
Selected Revision	Cystic Fibrosis (CF): Approval age was changed to ≥ 1 month of age, based on new indication; previously approval age was ≥ 4 months of age.	05/10/2023

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